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The purpose of this retrospective study is to determine the financial neutrality of the TRICARE Senior Prime program. TRICARE Senior Prime was created under the provisions of the 1997 Balanced Budget Amendments for Medicare Subvention Demonstration projects. TRICARE Senior Prime is a demonstration of the Military Health System's ability to conduct a Medicare+Choice style benefit for dual-eligible beneficiaries. Under the provisions of the program, the goal of the TRICARE Senior Prime is, through a joint effort by the Department of Health and Human Services and the Department of Defense's Military Health System, to implement a cost effective alternative for delivering accessible and quality care to dual-eligible beneficiaries while ensuring that the demonstration does not increase the total federal cost for either agency.

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CAN TRICARE SENIOR PRIME REMAIN BUDGET NEUTRAL FOR THE DEPARTMENT OF DEFENSE AND DEPARTMENT OF HEALTH AND HUMAN SERVICES?

A GRADUATE MANAGEMENT PROJECT SUBMITTED TO THE FACULTY OF THE U.S. ARMY-BAYLOR UNIVERSITY FOR SUCCESSFUL COMPLETION OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF HEALTH CARE ADMINISTRATION

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26 June 1999

ABSTRACT

The purpose of this retrospective study is to determine the financial neutrality of the TRICARE Senior Prime program. TRICARE Senior Prime was created under the provisions of the 1997 Balanced Budget Amendments for Medicare Subvention Demonstration projects. TRICARE Senior Prime is a demonstration of the Military Health System's ability to conduct a Medicare+Choice style benefit for dual-eligible beneficiaries.

Under the provisions of the program the goal of the TRICARE Senior Prime program is, through a joint effort by the Department of Health and Human Services and the Department of Defense's Military Health System, to implement a cost effective alternative for delivering accessible and quality care to dual-eligible beneficiaries while ensuring that the demonstration does not increase the total federal cost for either agency.

The analysis provides insight to how the program was created and areas that will provide a financial challenge for the Military Health System. The study found that the Military Health System has a disproportionately larger risk share in this program than the Department of Health and Human Services and can not remain budget neutral as the program is currently structured.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Background

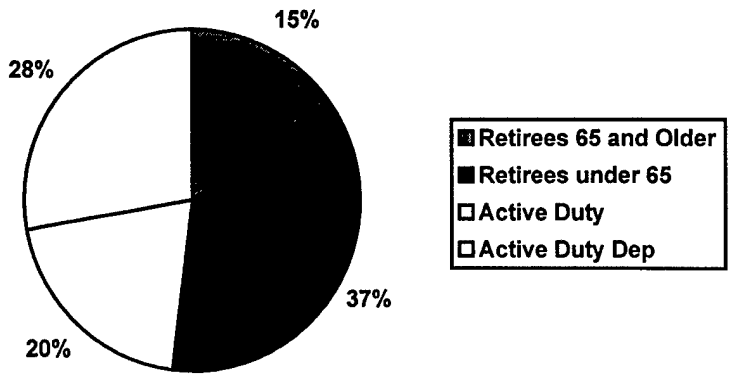
The Department of Defense's (DoD's) primary military medical mission is maintain the health of 1.6 million active duty personnel and to deliver health care during wartime.

The Assistant Secretary of Defense for Health Affairs defines the DoDs health mission as:

> The mission of the Military Health Services System (MHS) is, to provide medical services and support to the armed forces during military operations, and to provide continuous medical services to members of the armed forces, their dependents, and others entitled to DoD medical care.

In addition to this active duty force DoD offers health care services to 6.6 million non-active duty beneficiaries, including active duty members' dependents and military retirees and their dependents as reflected in Figure 1.

Figure 1. Population eligible for Military Health Care by Category, 1996.



Most care is provided in 115 hospitals and 471 clinics - called military treatment facilities (MTF's)- operated by the Army, Navy, and Airforce worldwide. This direct care delivery system is supplemented by DoD funded care in civilian facilities. In fiscal year 1997, DoD spent about $12 billion on direct care and about $3.5 billion on supplemental care (GAO 1998).

In response to such daunting challenges as increasing direct care health costs, out of control Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplemental expenditures, Base Realignment and Closure (BRAC) and problematic beneficiary access to care, DoD developed an alternative to its historical MHS health care delivery approaches. Congress in its National Defense Authorization Act for Fiscal Year 1994 (P.L. 103-106) directed DoD to prescribe and implement a nationwide managed health care benefit program modeled after health maintenance organization (HMO's) plans. TRICARE, implemented in 1998, is the MHS' managed care health program that combines the direct and supplemental care provided by DoD funded health programs into a tri-level HMO style health plan.

One of the guiding principles of the TRICARE Program is to optimize usage of MHS resources. Resource allocation and financing mechanisms have been designed to encourage improved efficiency and effectiveness. The MHS facilities are to be resourced based on capitation, which includes operation and maintenance dollars for direct care, CHAMPUS, and military personnel. These funds are allocated from the central Defense Health Program that was established to improve overall management of the military health services program.

Under the MHS capitation system, the commander of each MTF

assumes responsibility for providing health services to a defined population for a fixed amount per beneficiary. Regardless of the amount of health services used, there is no financial incentive under a capitated system to inappropriately increase the number of services. Capitation discourages inappropriate hospital admissions, excessive lengths of stay, and unnecessary services. Quality assurance and utilization management programs will monitor appropriate utilization of medically necessary services to ensure that budgetary controls do not erode the provision of needed care (Texidor et al., 1996).

The MHS is currently making the transition to an Enrollment Based Capitation (EBC) method of allocating health care resources to the Military Departments, which provides financial incentives for effective health care management. Using the EBC methodology MTF commanders are currently resourced based upon the number of enrolled TRICARE participants in their catchment areas.

Retiree organizations believe that EBC will severely limit the amount of space-available care provided for dual-eligible beneficiaries (Wieczorek 1997). Dual-eligible beneficiaries are Medicare-eligible military retirees who under the current interpretation of title 10 chapter 55 are eligible for space available care. With the erosion of space-available care in MTF's many dual-eligible beneficiaries are left with a sense of abandonment by the organization that has promised to take care of their health care needs for life (Wieczorek 1997).

Introduction

While the focus of the MHS is clearly stated as "mission focused" the environment surrounding the medical entitlements of retirees' has shifted as their numbers have grown. Armed with substantial political clout and energized by hollow "recruitment" promises, retirees are demanding that the MHS provide the cost, quality and access they require (Wieczorek 1997).

In an attempt to provide for its dual-eligible beneficiaries the Department of Health and Human Services (DHHS), the Health Care Financing Administration (HCFA), DoD and the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) have agreed to conduct a demonstration project under which DHHS will reimburse DoD from the Medicare Trust Fund for certain health care services provided to dual-eligible beneficiaries at a military treatment facility (MTF) or through contracts. This demonstration is referred to as the TRICARE Senior Prime, or TRICARE Senior.

TRICARE Senior will consist of two types of health care delivery systems: TRICARE Senior Prime and Medicare Partners. Under TRICARE Senior Prime, the Medicare program will treat the DoD and its MHS similar to a Medicare+Choice plan for dual-eligible Medicare/DoD beneficiaries. Medicare will pay for dual-eligibles enrolled in the DoD managed care program only after DoD meets its historic amount of expenditures utilized on retiree care known as its "level of effort" (LOE), measured in terms of health care expenditures for the dual-eligible population. Under Medicare Partners, DoD will receive payment from Medicare+Choice plans under Part C of title XVIII of the Social Security Act with which DoD contracts for inpatient and physician specialty care services provided to Medicare-eligible

military beneficiaries who are enrolled with the Medicare+Choice plans.

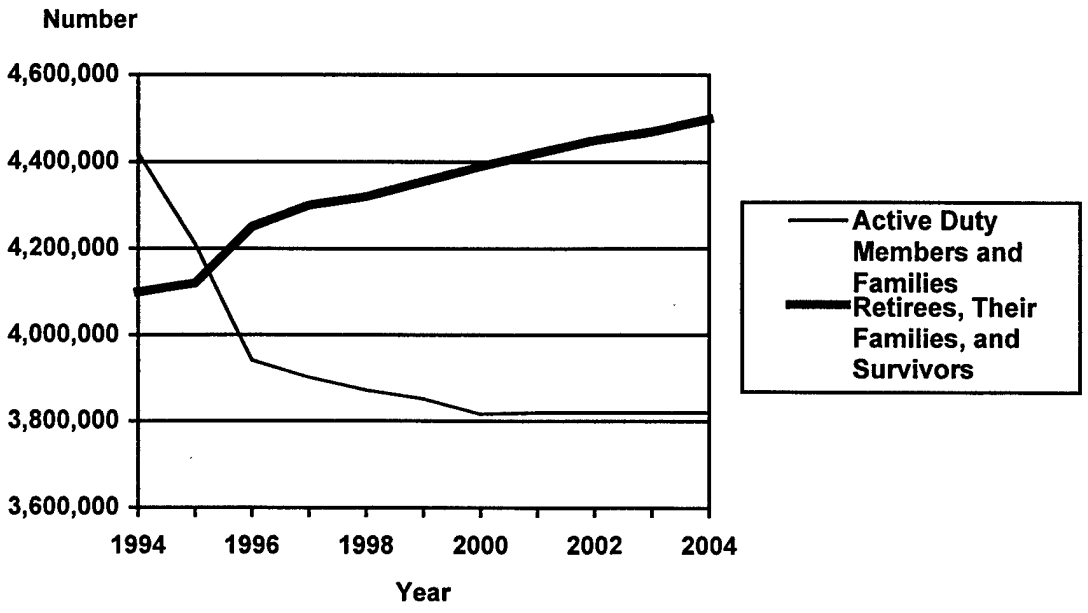
The goal of this demonstration is, through a joint effort by DHHS and DoD, to implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries while ensuring that the demonstration does not increase the total federal cost for either agency (MOA 1998).

The overall objective of this Graduate Management Project (GMP) is to evaluate the TRICARE Senior Prime program and determine the effects of its implementation on the Military Health System (MHS).

a. Conditions Which Prompted the Study

The MHS is facing increasing pressure from a variety of governmental agencies to decrease its size to a level that maintains wartime requirements, while simultaneously providing for an expanding retired beneficiary base that has eclipsed active duty and active duty dependant numbers Figure 2 (RAPS 1998).

Figure 2. Active Duty and Retiree Population Trends, 1994-2004.



To accomplish this mandated medical department rightsizing the MHS augmented its existing infrastructure by contracting with local providers to meet the dual mission of medical readiness and beneficiary health care delivery. TRICARE is the MHS's program that attempts to improve access, improve quality and control costs.

Only recently fully implemented, the TRICARE program faced strong opposition from retiree populations. Retirees who are Medicare eligible opposed TRICARE because they were denied access to the TRICARE options. DoD stated their inability to participate was because they were provided for in another federal program. In essence, they could be "locked out" of the military health care system as space available care wanes. Medicare Demonstration of Managed Care otherwise known as, TRICARE Senior Prime is the congressionally approved plan to bridge the gap left by TRICARE. The combination of both programs is intended to provide a comprehensive managed care benefit plan to dual eligible beneficiaries.

In this paper the evolution and policies of TRICARE and its Senior Prime Program are examined, as well as their potential impact on military medical readiness and the fiscal future of the MHS and the Medicare Trust Fund. This will be accomplished by analyzing how the current demonstration project was designed, collecting data on the dual-eligible beneficiaries when compared to other similar Medicare Risk HMO's, and outlining potential pitfalls with the program as well as recommending potential alternatives.

b. Statement of the Problem

The research question, framed within the environment of MHS Medicare managed care, is: **Can TRICARE Senior Prime achieve its intended purpose, and remain budget neutral for the MHS and DHHS?**

The Medicare Demonstration of Military Managed Care Memorandum of Agreement clearly states "the goal of this plan is to implement a cost effective alternative while ensuring that the demonstration does not increase the total federal cost for either agency". However, the Government Accounting Office (GAO) determined in its June 1997 report, "Military Retirees' Health Care," that the MHS lacks the cost and care data needed to accurately estimate current spending levels for its Medicare eligible retirees.

This statement is significant for the following reason; if the MHS inaccurately calculated its spending levels for these dual eligible retirees' it would result in a Level of Effort (LOE) that is set incorrectly for the MHS. An accurate LOE is key to ensuring Medicare Subvention cost-neutrality. If the MHS LOE baseline is set too high, the MHS will pay for care that was previously Medicare's responsibility, resulting in resource shifting within the already limited Defense Budget. If the MHS LOE is too low, Medicare will have increased fiscal responsibility resulting in deficit spending from a beleaguered Medicare Trust Fund.

For the MHS, a LOE baseline that is set too high coupled with HCFA negotiated reimbursement rates set lower than what is paid to Medicare HMO's equates to a serious magnification of the financial risk to the MHS and DoD. It is imperative that the MHS set its LOE at the correct level for this program to achieve its intended benefits.

c. Literature Review

The success of the TRICARE Senior Prime program rests entirely on the cost projections developed by HCFA and the DoD's MHS. After its review of Medicare subvention legislation, the Congressional Budget

Office (CBO) reported that the program's cost-neutrality critically hinges on how accurate the MHS is able to establish its LOE baseline spending on Medicare eligible beneficiaries (CBO 1996). The DoD MHS computed the FY96 LOE separately for the six Medicare Demonstration site service areas. The combined MHS LOE for these six service areas was set at approximately $170 million (HA 1998). Table 1. denotes the implementation schedule, total number of eligible beneficiaries, and projected enrollment capacity at each site.

Table 1.

TRICARE Senior Prime Sites and Schedules

Site	Site LOE (millions)	Number Eligible	Enroll Capacity	Enroll Start Date	Start of Health Care Delivery
Madigan Tacoma, WA	$27.4	18,300	3,300	7/15/98	9/1/98
San Antonio, TX	$77.3	33,100	10,000	8/15/98	10/1/98
San Diego, CA	$27.2	33,400	4,000	9/15/98	11/1/98
Ft.Sill, OK and Sheppard AFB,TX	$7.5	6,800	2,700	9/15/98	11/1/98
Keesler AFB, Biloxi, MS	$15.3	7,100	3,100	10/15/98	12/1/98
Colorado Springs, CO	$13.6	13,200	3,200	10/15/98	12/1/98
Dover AFB Dover, DE	$3.5	3,800	1,500	10/15/98	12/1/98
TOTAL	$171.8	115,700	27,800		

Note. From "Medicare Demonstration of Military Managed Care": Memorandum of Agreement (1998).

The DoD's current systems capture information on the type and cost of medical services provided by individual facilities but cannot attribute facility costs to specific patients or groups of patients, e.g., dual-eligible beneficiaries. After its review of the LOE methodology, the Government Accounting Office (GAO) reported that the risk of reporting an inaccurate LOE baseline would be great because of the limitations of the DoD's cost and utilization data (GAO 1997).

The challenge to successful management of a managed care organization (MCO) lies in the MCOs' ability to produce timely and accurate financial reports (Kongstvedt 1996). The TRICARE Management Activity (TMA 1998) states that "data quality is paramount and MEPRS data are key to accurate cost determination and pricing" (p.31).

Unexpected "incurred but not reported" expenses have torpedoed more managed care plans than any other cause. As growing managed care plans develop problems with operations, i.e., the authorization system, claims, or data gathering in general, medical expense and utilization reports frequently suffer (Kongstvedt 1996).

The Institute for Defense Analysis (IDA) in its 1994 report, "Cost Analysis of the Military Medical Care System" often referred to as the "733 study," recommended further development of MEPRS to reduce what it referred to as "serious data inconsistencies" (IDA 1994). The IDA attempted to compensate for data inconsistencies by developing adjustment factors that attempt to render MEPRS cost data comparable to that collected in the civilian sector. The IDA concluded that in many cases, the care provided by military providers was more cost effective than civilian providers (all things being equal). However, there has been concern from numerous sources about the validity and applicability of the 733 study data (GAO 1998).

The purpose of MEPRS for DoD Medical operations is to provide a uniform healthcare cost management system for the DoD (MEPRS,1994). MEPRS also provides detailed, uniform performance indicators, common expense classification by work center, uniform reporting of personnel utilization data by work center, and a cost assignment methodology. MEPRS is the basis for establishing a uniform reporting methodology that provides consistent financial and operating performance data to assist managers who are responsible for healthcare delivery in the fixed military medical system.

The MEPRS defines a set of functional work centers, applies a uniform performance measurement system, prescribes a cost assignment methodology, and obtains reported information in a standard format for each fixed medical treatment facility. Resource and performance data must reflect the resources used in delivering healthcare services; be recorded on a current, accurate, and complete basis in sufficient detail to permit management review and audit of the recorded and reported data; and comply with MEPRS functional work center requirements.

Many of today's hospital information systems can not support the sophisticated data collection and analysis requirements needed to effectively keep pace with competing health care providers. To accommodate cost studies at the program and system level, relational information systems must be developed that allow costs to be summed across individuals to determine an organization's costs, across providers to determine an individual patient's costs, and across both to determine system and population costs (Ehreth 1996). The GAO in its report "Military Retirees' Health Care" (1997) noted that the MHS

lacked the ability to effectively collect episodic or patient level cost data.

As a health plan grows it is not uncommon that the Management Information System (MIS) is unable to change at the same pace without a prohibitively high cost in programming and time. Groups accepting full-risk capitation need strong financial management skills and good computer systems support (Kongstvedt 1996).

The MHS's ability to accurately predict its LOE is not the only critical factor in the success of this program. Reduced Medicare payment rates, expanded levels of service, and a patient population that consumes significant amounts of the available health care dollar promises to make the Senior Prime program difficult to administer at best. In 1998 HCFA and DoD entered into a Memorandum of Agreement for the Medicare Demonstration of Military Managed Care. The agreed on reimbursement rate by Medicare to DoD (after it meets its LOE) is 95 percent of the applicable Medicare+Choice rate as determined under the Balanced Budget Act of 1997 (MOA 1998). The MOA outlines payment rates ranging from 90 to 93 percent of Medicare's estimated average cost. This equates to a minimum of two percentage points lower than HCFA pays to private Medicare HMOs. The DoD agreed to the reduced rate because it believes it can provide care to older retirees in MTFs at a lower cost than Medicare HMOs. This contention is based on the "733 study," which compared the cost of providing care to DoD beneficiaries in MTFs with the cost of providing care in the civilian sector (GAO 1997).

HCFA in the MOA with the DoD required that the MHS compute the LOE expenditures for its Medicare eligible beneficiaries for each demonstration site. HCFA stated that the MHS had to exceed the LOE

to receive any additional funding for care rendered to dual-eligible beneficiaries (MOA 1997).

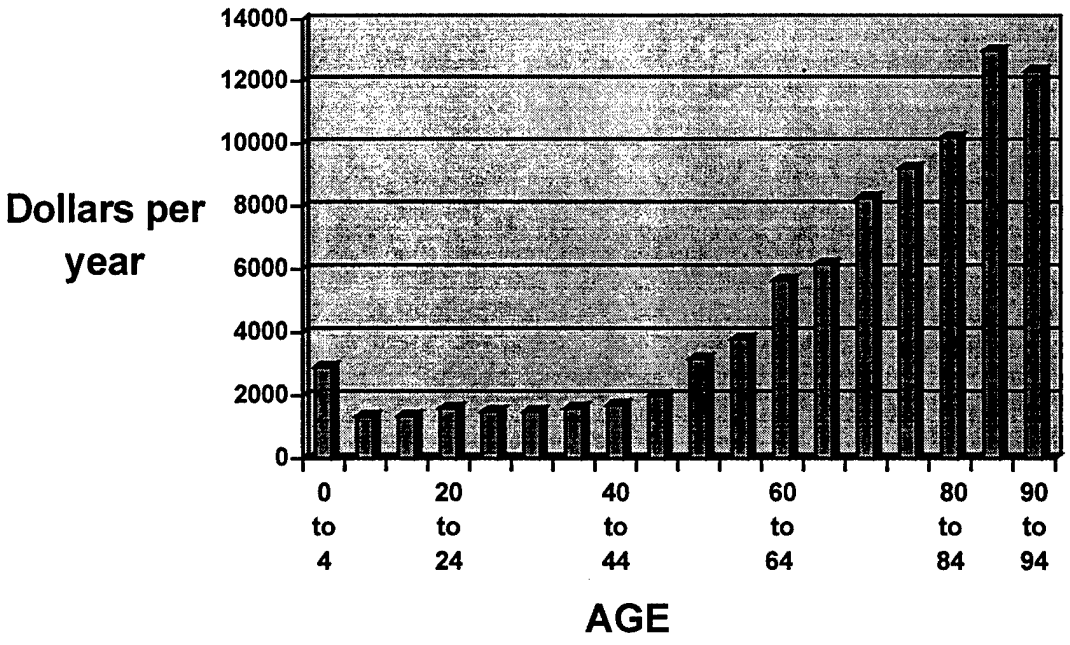
The trust fund has never been on a balanced budget accrual accounting basis. Each year's receipts (taxes) go into the trust fund and each year's claims are paid out, without earmarking any of the receipts as funding any future outlay. In fact, each year there have been excess receipts over claims (due to the relative youthfulness of the baby-boomers) which have been used to lend money to other parts of the federal government to be spent.

Officially, the trust fund still holds this excess money, but in reality, it holds treasury bonds from the federal government that spent the money. As the baby-boomers reach Medicare age the trust fund is forecast to go bankrupt because the sum of new receipts and matured treasury bonds will not cover the expected increase in claims. In short, while the trust fund always got the employment taxes from our eventual dual eligibles, they were not expected to park this money somewhere to cover those people when they needed it. They, just like DoD, are on a cash basis (Holmes 1999). "DoD has historically had appropriate funds to provide care to the dual eligibles. If the MHS were to quit providing services to its dual-eligibles, it should lose that portion of its appropriation" (Ashby 1999).

In reviewing the requirements of the growing elderly population, it is easy to see why the MHS may be in for financial difficulties if it has failed to accurately estimate the cost of treating dual-eligible beneficiaries. "Fifty-eight percent of health care dollars are spent on fewer than five percent of the population" (Feldstein 1994). This five-percent of the population is primarily comprised of

neonates and those over 65. HCFA estimates that the number of over sixty-five year old beneficiaries will dramatically increase as the baby boomers reach Medicare eligibility ages. Figure 3 Depicts the amount of dollars spent on various age groups.

Figure 3. Age and average per capita annual health care costs



Note: Data as of June 30, 1997.
Source: HCFA, Bureau of Data Management and Strateg

A review of MHS cost accounting literature revealed two previous studies relevant to the research question. The studies focused on cost allocation methods within the MHS.

Goldberg, Chin, Dorris, and Horowitz (1994) collaborated on an Institute for Defense Analyses (IDA) cost analysis of the military health care system i.e. the 733 study. The study's purpose was to analyze the cost structure of military hospitals. The IDA also

developed models that relate cost to workload for individual military hospitals. The IDA's models were based on data from MEPRS, which is known to understate some of the cost elements. The study developed adjustment factors that increase specific multipliers by 11% to 17% to adjust for the understatements.

The Government Accounting Office in its report "Military Retirees' Health Care: Cost and Other Implications of Options to Enhance Older Retirees' Benefits" outlined several options to delivering dual-eligible beneficiaries health care needs and the cost to the individual as well as DoD. The GAO concluded that "DoD's lack of information with which to accurately determine its current LOE raises questions about whether the program would actually be cost neutral (GAO 1998). This research project attempts to answer this GAO statement.

Purpose

The purpose of this study is to evaluate whether the TRICARE Senior Prime option can remain budget neutral, as stated in one of the program's goals. The supporting objectives of this study are to identify the critical factors associated with success in Medicare+Choice HMO Managed Care plans, identify areas of potential weakness in HCFA's and DoD's claim of financial neutrality, and provide alternatives and recommendations to the TRICARE Senior Prime financial plan.

Methods and Procedures

To adequately address the research question, "Can TRICARE Senior Prime remain budget neutral for the DoD and the DHHS?" the following

objectives are explored:

a. To what extent are the LOE projections in the TRICARE Senior Prime Demonstration valid.

b. The process by which DoD develops its cost and expense reporting systems.

c. What effect will the shift in patient population (aging) have on the LOE's 1991 based demographic projections?

d. Can MEPRS derived data deliver accurate Patient Level Cost Accounting for policy level decisions?

The aforementioned objectives were addressed utilizing various qualitative research approaches to include In-depth interviewing, Secondary Data Analysis and Document Analysis (Strauss 1998).

The inception period of the TRICARE Senior Program was studied in an exploratory case study format. Specifically, events concerning the adoption of the LOE and executive decisions supporting monetary contributions and transfers from each agency.

Secondary data analysis was augmented with personal interviews with Chris Visnesky the MEPRS coordinator at Great Lakes Naval Hospital (objective (a)), and the developers of the current TRICARE Senior Plan in the DHHS and DoD. Dr. Jack Ashby of the Medicare Payment Advisory Commission (MEDPAC) was interviewed for Medicare Specific Questions. Additionally, a series of interviews were conducted with Dr. Richard Guerin, TMA/Office of the Assistant Secretary of Defense for Health Affairs the creator of the LOE methodology to address objective (b). The primary researcher conducted a TRICARE Senior Prime implementation interview with Major Montiplaisir, the TSP Administrator of Wilford Hall Medical Center, San Antonio, TX one of the programs test sites to obtain his reaction

to MEPRS data and policy level decisions (objective (d)).

Further, the plan is financially modeled using HCFA proposed payment schedules. Medicare Payment Advisory Commission rates used in this study are specific to the particular subvention site. Medicare's cost of providing care to these estimated 27,800 patients in the demonstration projects is outlined as if no care was provided in MTF's.

The effects of using outdated 1991 data on the development of dual-eligible beneficiary population data for the LOE estimates was normed by adjustment ratios provided in the Prospective Payment Assessment Commissions: Report to Congress (PPAC 1997). This "adjusted" data was used to update the actual cost to the participating MTF's (objective(c)).

Results

The study found that the TRICARE Senior Prime Program could not remain budget neutral to both the MHS and the DHHS Cost avoidance, LOE miscalculations, and increasing costs of care for the elderly impacted the program's financial neutrality. The following tables and figures will aid in outlining just a few of the potentially serious impacts on the program's budget neutrality. It should be noted however, that in the process of determining the benefit of the program, each agency had numerous considerations other than financial. Other factors considered will be reviewed in the discussion portion of this paper.

Arguably the area with the most impact on the financial neutrality of the program is the determination of the MHS's historical effort. The MHS has agreed to the premise that

appropriations were added to its historic base to care for its dual eligible beneficiaries. However, the $170+ million detailed in the six site LOE can also be viewed as a cost avoidance to the Medicare Trust Fund. Table 2 outlines the Adjusted Average Per Capita Cost (AAPCC) rate Medicare would have had to pay for a Medicare HMO.

TABLE 2

Six site (non TRICARE Senior Prime) Medicare AAPCC rate

Site	County	Enollees	AAPCC part A	part B	PMPM	Annual PMPY
Madigan	King	3300	255.62	189.95	$ 1,470,381	$ 17,644,572
San Antonio	Bexar	10000	288.04	214.03	$ 5,020,700	$ 60,248,400
San Diego	San Diego	4000	308.7	229.39	$ 2,152,360	$ 25,828,320
Ft Sill OK, Sheppard AFB, TX	Aver of both	2700	227.21	169.51	$ 1,071,144	$ 12,853,728
Keesler AFB Biloxi, MS	Harrison	3100	335.56	249.35	$ 1,813,221	$ 21,758,652
Colorado Springs, Co	El Paso	3200	252.67	187.75	$ 1,409,344	$ 16,912,128
Dover AFB, DE	Kent	1500	235.87	175.27	$ 616,710	$ 7,400,520
TOTAL		27800			$ 13,553,860	**$ 162,646,320**
				average weighted pmpy		**$ 5,850.59**
				average wieghted pmpm		**$ 487.55**

PMPM = per member per month
PMPY = per member per year

Table 3 outlines the first year cost avoidance enjoyed by the implementation of the TRICARE Senior Prime Demonstration given that total enrollment is reached and Medicare is required to meet it's cap of $50 million. In the situation presented (total enrollment and or 70% cap on Space A care) Medicare will benefit with a $112+ million cost avoidance. If the enrollment or Space A goals are not met Medicare will enjoy an even larger cost avoidance.

TABLE 3

MEDICARE TRUST FUND COST AVOIDANCE

Six site avg pmpm AAPCC rate	$	487.55
Potiential annual cost to Medicare w/o MHS*	$	162,646,320.00
Potiential annual cost to Medicare under TSP		
1st year payment cap**	$	50,000,000.00
Medicare cost avoidance	**$**	**112,646,320.00**

*Does not include space A care
**Payment received after LOE is met includes space A care

MEPRS data has been the main source of data for determining the cost of the program. Labor costs are responsible for nearly 60% of the LOE projections (Guerin 1998). These labor costs were arrived at utilizing the MEPRS Composite Pay scale. The Composite Pay scale is a service specific pay scale, which is used to norm all variations in pay within pay grade. It is a composite that accounts for Basic pay, Retired pay accrual, Basic Housing Allowance, Incentive and Special Pay and Miscellaneous expenses to arrive at one annual payment for each specific pay grade. The composite pay scale has been criticized for its use in MEPRS due to under reporting the abnormally high medical bonuses received by Medical personnel. Conversely, composite scaled pay for non-clinicians may be overstated because such personnel receive significantly less (actual dollar value) in special and incentive pays than other occupational specialties that receive flight and sea pays. Table 4 is a one-facility Brooke Army Medical Center (BAMC) sample of the military composite pay scale.

Table 4

Brook Army Medical Center MEPRS Composite Pay Scale

Cat.	n	Grade	MEPRS$	MEPR Total
Military	1	GO	$ 132,823.00	$ 132,823.00
Military	53	COL	$ 125,212.00	$ 6,636,236.00
Military	127	LTC	$ 101,120.00	$ 12,842,240.00
Military	191	MAJ	$ 87,507.00	$ 16,713,837.00
Military	401	CPT	$ 72,640.00	$ 29,128,640.00
Military	90	1LT	$ 53,486.00	$ 4,813,740.00
Military	100	2LT	$ 41,275.00	$ 4,127,500.00
Military	1	W03	$ 66,989.00	$ 66,989.00
Military	1	W02	$ 56,349.00	$ 56,349.00
Military	6	E9	$ 65,904.00	$ 395,424.00
Military	22	E8	$ 55,675.00	$ 1,224,850.00
Military	63	E7	$ 47,931.00	$ 3,019,653.00
Military	113	E6	$ 40,984.00	$ 4,631,192.00
Military	258	E5	$ 34,847.00	$ 8,990,526.00
Military	284	E4	$ 29,082.00	$ 8,259,288.00
Military	111	E3	$ 24,236.00	$ 2,690,196.00
Military	61	E2	$ 22,538.00	$ 1,374,818.00
Military	25	E1	$ 21,599.00	$ 539,975.00
	1908			$ 105,644,276.00
Cat.	**n**	**Grade**	**MEPRS$**	**MEPR Total**
GS	7	15	$ 92,512.00	$ 647,584.00
GS	2	14	$ 78,648.00	$ 157,296.00
GS	8	13	$ 66,555.00	$ 532,440.00
GS	25	12	$ 55,967.00	$ 1,399,175.00
GS	148	11	$ 46,698.00	$ 6,911,304.00
GS	39	10	$ 42,502.00	$ 1,657,578.00
GS	123	9	$ 38,595.00	$ 4,747,185.00
GS	54	8	$ 34,942.00	$ 1,886,868.00
GS	97	7	$ 31,551.00	$ 3,060,447.00
GS	126	6	$ 28,391.00	$ 3,577,266.00
GS	237	5	$ 25,472.00	$ 6,036,864.00
GS	196	4	$ 22,766.00	$ 4,462,136.00
GS	51	3	$ 20,281.00	$ 1,034,331.00
GS	32	2	$ 18,587.00	$ 594,784.00
GS	3	1	$ 16,631.00	$ 49,893.00
				$ 36,755,151.00

Table 5 is a list of the 1998 annual bonuses received by medical officers at BAMC. It is only applicable to 200 of the 1906 officers

at BAMC but it accounts for over $10 Million dollars in additional expenses when added to the actual salaries of BAMC's medical officers.

Table 5.

BAMC Annual Medical Bonus Structure (Military Only)

Spec	n	V.S.P	A.S.P	B.C.P.	I.S.P	MYSP	Gross Add
Allergy	2	10,000	15000	4000	0	0	$ 58,000.00
Cardio	11	10,000	15000	4000	0	0	$ 319,000.00
Endo	4	10,000	15000	4000	0	0	$ 116,000.00
Gastro	6	10,000	15000	4000	0	0	$ 174,000.00
Int Med	9	10,000	15000	4000	13000	10000	$ 468,000.00
Hem/onc	6	10,000	15000	4000	0	0	$ 174,000.00
Inf Dis	4	10,000	15000	4000	0	0	$ 116,000.00
Nephrol	2	10,000	15000	4000	0	0	$ 58,000.00
Neuro	5	10,000	15000	4000	12000	8000	$ 245,000.00
Pulm Dis	6	10,000	15000	4000	0	0	$ 174,000.00
Rheum	3	10,000	15000	4000	0	0	$ 87,000.00
Derm	7	10,000	15000	4000	13000	8000	$ 350,000.00
Anesth	14	10,000	15000	4000	31000	0	$ 840,000.00
C/T Surg	3	10,000	15000	4000	35000	8000	$ 216,000.00
Crit Care	2	10,000	15000	4000	21000	10000	$ 120,000.00
Gen Surg	6	10,000	15000	4000	28000	10000	$ 402,000.00
Nuero Sur	3	10,000	15000	4000	35000	8000	$ 216,000.00
Opthalmo	8	10,000	15000	4000	31000	0	$ 480,000.00
Ortho	7	10,000	15000	4000	35000	14000	$ 546,000.00
Otor	5	10,000	15000	4000	29000	8000	$ 330,000.00
VasSurg	2	10,000	15000	4000	35000	8000	$ 144,000.00
Urology	4	10,000	15000	4000	26000	14000	$ 276,000.00
Peds	20	10,000	15000	4000	9000	8000	$ 920,000.00
Ob/Gyn	8	10,000	15000	4000	31000	10000	$ 560,000.00
Emer	9	10,000	15000	4000	18000	10000	$ 513,000.00
Path	8	10,000	15000	4000	15000	8000	$ 416,000.00
Radiolo	18	10,000	15000	4000	31000	8000	$ 1,224,000.00
Physical	2	10,000	15000	4000	9000	10000	$ 96,000.00
Prev Med	1	10,000	15000	4000	9000	10000	$ 48,000.00
Fam Prac	2	10,000	15000	4000	8000	14000	$ 102,000.00
Psych	3	10,000	15000	4000	10000	10000	$ 147,000.00
Other	8	0	15000	0	0	0	$ 120,000.00
	200						$ 10,055,000.00

VSP = Variable Special Pay
ASP = Additional Special Pay
BCP = Board Certified Pay
ISP = Incentive Special Pay
MYSP = Multi Year Special Pay

Table 6 is the annual military salary for BAMC. It removes the composite pay scale incentive pay averages for all ranks and adds only the Military Medical Officer Bonus pays. The composite bonuses totaled $2,647,024 (all ranks) while the medical officer special pay added $10,055,000 a delta of $7,407,976 under reported using MEPRS Composites.

Table 6

BAMC actual annual military pay

Cat.	N	Grade	MEPRS Composite Pay Reported for LOE	BAMC A/D MEPRS Total	MEPRS composite incentives	Less sevice wide incentives	MEPRS Adjusted Total	BAMC Annual Medical Bonuses
Military	1	GO	$ 132,823.00	$ 132,823.00	$ 1,621.00	$ 1,621.00	$ 131,202.00	
Military	53	COL	$ 125,212.00	$ 6,636,236.00	$ 6,144.00	$ 325,632.00	$ 6,310,604.00	
Military	127	LTC	$ 101,120.00	$ 12,842,240.00	$ 2,704.00	$ 343,408.00	$ 12,498,832.00	
Military	191	MAJ	$ 87,507.00	$ 16,713,837.00	$ 3,598.00	$ 687,218.00	$ 16,026,619.00	
Military	401	CPT	$ 72,640.00	$ 29,128,640.00	$ 2,442.00	$ 979,242.00	$ 28,149,398.00	
Military	90	1LT	$ 53,486.00	$ 4,813,740.00	$ 712.00	$ 64,080.00	$ 4,749,660.00	
Military	100	2LT	$ 41,275.00	$ 4,127,500.00	$ 453.00	$ 45,300.00	$ 4,082,200.00	
Military	1	W03	$ 66,989.00	$ 66,989.00	$ 3,245.00	$ 3,245.00	$ 63,744.00	
Military	1	W02	$ 56,349.00	$ 56,349.00	$ 1,529.00	$ 1,529.00	$ 54,820.00	
Military	6	E9	$ 65,904.00	$ 395,424.00	$ 193.00	$ 1,158.00	$ 395,231.00	
Military	22	E8	$ 55,675.00	$ 1,224,850.00	$ 203.00	$ 4,466.00	$ 1,224,647.00	
Military	63	E7	$ 47,931.00	$ 3,019,653.00	$ 203.00	$ 12,789.00	$ 3,019,450.00	
Military	113	E6	$ 40,984.00	$ 4,631,192.00	$ 215.00	$ 24,295.00	$ 4,630,977.00	
Military	258	E5	$ 34,847.00	$ 8,990,526.00	$ 227.00	$ 58,566.00	$ 8,990,299.00	
Military	284	E4	$ 29,082.00	$ 8,259,288.00	$ 201.00	$ 57,084.00	$ 8,259,087.00	
Military	111	E3	$ 24,236.00	$ 2,690,196.00	$ 193.00	$ 21,423.00	$ 2,690,003.00	
Military	61	E2	$ 22,538.00	$ 1,374,818.00	$ 188.00	$ 11,468.00	$ 1,374,630.00	
Military	25	E1	$ 21,599.00	$ 539,975.00	$ 180.00	$ 4,500.00	$ 539,795.00	
	1908		MEPRS reported	$ 105,644,276.00		**$ 2,647,024.00**	$ 102,997,252.00	**10,055,000**
			Less MEPRS averaged incentive pay (all ranks)	$ 2,647,024.00				
			Add Army Medical Incentives (Medical officers only)	$ 10,055,000.00	* Note enlisted actual bonuses were not added			
			Acutal Cost	$ 113,052,252.00				
			BAMC under reported staff cost to LOE	**$ 7,407,976.00**	* higher if enlisted sp/bonuses added			

Table 7 is a sample of two sites stratified by age to determine if adverse or beneficial selection of program participants took place in the TSP program.

TABLE 7

Naval Hospital San Diego TSP Applicants Age Breakdown

Age	San Diego		Wilford Hall		National	
65-74 years	1979	63%	3112	61%	18,104,000	54%
75-84 years	1004	32%	1721	34%	11,255,000	34%
85 years +	153	5%	302	6%	3,905,000	12%
	3136	100%	5135	100%	33,264,000	100%

TABLE 8 outlines enrollment goals for the demonstration's six sites. As of April 26, 1999 the GAO recorded the demonstration enrollment rate to 84.8%.

TABLE 8 TRICARE Senior Prime Enrollment rates

Site	Enrolled	Capcity	Enrolled as % Capacity	Total Eligible
Madigan Army Med Cen, Wa	3,296	3,300	99.9	21,709
San Antonio, TX	11,534	12,700	90.8	41,215
Naval Med Cen, San Diego, CA	2,767	4,000	69.2	35,619
Keesler Medical Center, MS	2,563	3,100	82.7	7,361
Colorado Springs, CO	2,744	3,200	85.8	13,689
Dover, DE	661	1,500	44.1	3,905
TOTAL	23,565	27,800	84.8	123,498

Note: status as of April 26,1999
(GAO 1999)

Discussion

As demonstrated in the research methodology and results, there were many variables involved in answering the primary research question of the programs financial neutrality. The calculation of the LOE, MEPRS applicability as a patient level cost accounting system, appropriate levels of reimbursement, expanded benefits and rapidly changing demographics within the MHS were all essential in evaluating the cost of the TRICARE Senior Prime program.

The areas with the greatest impact on financial neutrality were the initial discussions of the program leading to the acceptance of the LOE assumptions. Several factors led to the DoD's acceptance of the requirement that the MHS exceed a LOE threshold prior to payment from HCFA. The BBA of 1997 (P.L. 105-33) placed a limit on the amount of expense the Medicare program could undertake. The research found that the capped amount is not entirely accurate given that no increases were to be incurred. The DHHS capped the first year of its total expenditures at $50 Million. Table 3 shows that the Medicare Trust Fund would have had to pay $162 Million for the care of the 27,800 enrollees given no MHS involvement. The resulting $112 Million is a cost avoidance for the Medicare Trust Fund. Mr. Jack Ashby the principal policy analyst of the Medicare Payment Advisory Commission explained that the Military had historically funded, through DoD appropriations, the partial care of many of its dual eligible beneficiaries and should continue to do so as Medicare views itself as a secondary payer.

The MHS agreed in initial MOU discussions with the DHHS that it would meet historic LOE. The MHS was further tasked by DHHS to determine a methodology to derive how much health care its dual

eligible beneficiaries consumed minus pharmacy costs (not a Medicare benefit). The MHS developed a complicated procedure to gather data on this dual-eligible population utilizing MEPRS, CHCS, ADS and SADR/SIDR systems. The MHS came up with a number of approximately $170 million for the six sites. There has been a great deal of controversy over the accuracy of the data collection systems and techniques employed by the MHS. As discussed earlier an LOE set too high would appear to place the MHS at risk, while set too low the DHHS appears to be at risk. Neither is an accurate statement while determining LOE repayment between the MHS and DHHS. The research suggests that the accuracy in the LOE is moot given that the MHS 1998 $170 million dollar LOE is expensed utilizing the same 1996 methodology that was used to derive the historic expenditures.

Frequent users of the MEPRS system acknowledge that often the data is flawed and the system is not ideal for collection of patient level cost data, MEPRS wasn't designed for this function. However, the system does have the ability to evaluate one facility, service, or product line against others within the MHS. The value of MEPRS data for business decisions outside the MHS is difficult to determine. This point is significant in that the MHS has used this system as a base determinate for make versus buy decisions. Table 6 demonstrates one of potentially many examples of how MEPRS data is not accurate for comparing services outside of the MHS.

An additional confounding factor with the data reporting accuracy is that differing services report MERRS data in various ways. The Air Force reports its civilian pay as composite pay while the Army and Navy report actual payments. Each service reports depreciation of equipment differently. The differences in service specific reporting

methods and techniques cause financial inconsistencies, these financial inconsistencies are magnified especially when they are used for grouped data in a MHS wide price compilation.

The DoD's confidence in the MHS's ability to provide less expensive health care than its civilian counterparts may have led the DoD to accept lower reimbursement rates on the AAPC payments from HCFA. Two factors are critical in evaluating the TSP program's appropriate level of reimbursement. First, did the MHS set its enrollment capacity at a position too close to the actual payment threshold? For the plan to obtain budget neutrality the targeted enrollment, plus the Space A care rendered would need to be set at a level that would consume the LOE credits and the entire $50 million allotted by HCFA.

"A successful financial plan would have added the expanded Medicare+Choice benefits as marginal costs above space A, while managing these costs to be less than the marginal revenues received from HCFA AAPC reimbursement. If the enrollment capacity was set at the payment threshold from the outset, as it appears it was, all marginal costs would be incurred with no marginal revenue to cover them" (LTC Holmes, 1999). The situation is made worse by failure to reach optimal enrollment.

Second, did the MHS meet its enrollment goals? In the process of developing the demonstration targeted enrollment thresholds were used to calculate funding streams that would obtain budget neutrality. The demonstration as of April 26, 1999 was at 84% of targeted enrollment. As appears to be the case, the MHS in some areas is unable to meet its targeted enrollment? This is problematic when the program is viewed on aggregate performance. The MOU clearly outlines

restrictions placed on the payment of HCFA's contribution to the demonstration to be capped at 50 million dollars. The MHS LOE credits must first be exhausted prior to retention of any HCFA funds. Additionally, a maximum of 70% of the total LOE can be applied to Space A care provided by the participating facilities. The demonstration's failure to meet enrollment goals will result in few if any of the HFCA allowance being retained after reconciliation.

Conclusions and Recommendations

The TRICARE Senior demonstration is mandated to remain cost neutral for the DHHS budget by the placement of a $50 million dollar spending cap. The MHS does not have the same guarantee. With less than a full year of implementation in the demonstration the MHS has incurred higher than expected administration costs, lackluster enrollment rates and has yet to determine an accurate cost for the supplemental care rendered in the community.

The TRICARE Senior Prime demonstration will meet most of its intended objectives; increased benefits for enrollees, increased choice and access. However, it will fall short of its intended cost reduction goal. In aggregate the program cannot be delivered at an expense rate equal to, or slightly lower than other civilian managed care plans. The demonstration cannot provide the care without increasing the overall cost to the Federal government for the following reasons.

1. Loss of primary payers, beneficiaries who selected the TSP option gave up additional private insurance. The MHS has not accurately predicted the impact of providing total comprehensive care minus private insurance. HCFA estimates 18.4% and 32.2% of the total health care costs of care for the over 65 are provided by the patient

and private insurance respectively (HCFA 98). Previously, the MHS would be eligible to receive payment for care rendered through a third party payer such as private supplemental insurance policies while avoiding potentially 30% of the bill. With TSP the beneficiaries use only Medicare part B as a supplemental payer (after LOE is met). The MHS has become the primary payer with Medicare as the Secondary payer. The end effect is Medicare's out of pocket cost are reduced while the MHS increases its financial liability for its dual eligible nearly 50.6% from pre-TSP arrangements (minus any TRICARE co-payments which are designed to be markedly reduced).

2. Lower than expected enrollment rates places enrollment below the neutral payment threshold. Only two facilities, Wilford Hall Air Force Medical Center, San Antonio, TX. and Madigan Army Medical Center, Tacoma, WA. met enrollment goals. With the MHS at or below the neutral payment threshold the MHS will be required to seek additional funding or reprogram other funding lines at the decrement of the active duty force.

3. Increased pharmaceutical costs, regular Medicare+Choice plans do not cover pharmaceuticals. This benefit is estimated to be the most rapidly rising segment of health care costs (HCFA 1998). Currently, over 9% of the Military Health systems $15.7 billion budget is pharmacy related costs (Tomich, 1999). With patients requesting drugs by name and elderly patients on numerous prescriptions the cost to the MHS will greatly exceed its current level.

4. DoD agreed to a lower AAPC reimbursement amount than HCFA pays private HMOs, because DoD believed it could provide the care less expensively. This belief may in fact be the result of DoD's

inability to compile current, accurate or comparable "outside MHS" patient level cost accounting data.

5. Long Term Care, Skilled Nursing Facility and Rehabilitation care contracts are increasingly difficult to negotiate. MTF's are finding it difficult to contract for long term care at a rate that would not require them to contribute operational funding. The MHS receives 67% of civilian HCFA payment rates after GME, DSH and the negotiated 5% are removed. In order for the MHS to fund out-of-network costs it must contract at a rate near break even. There is little incentive for civilian institutions to accept a reimbursement rate significantly lower than the already beleaguered Medicare payment rates.

6. Inaccurate base line age and usage estimate for 1998 start of service. The MHS under estimated the projected amount of benefits received by dual-eligible beneficiaries due to use of 1991 beneficiary survey.

An exit strategy will be hard to find for this program if needed. This is due to a high rate of satisfaction by dual-eligible retirees participating in the fledgling program. The failure to expand this program could appear as yet another MHS failed promise to our retirees. To the beneficiary the program's failure will appear to be another case of poor benefits management. The MHS is in a precarious position, if the program fails, it would appear to be the MHS who even with "additional" funding from Medicare benefits couldn't provide the care required.

The financial failure of the TRICARE Senior Prime program is secondary to the failure of the Federal Government to follow the same type of consumer protection laws it passes to ensure civilian

retirement plans. For the Federal Government to be a viable financial entity, it should have funded its programs at the same time the benefits were received, through the government setting aside the promised payments in a separate, secure retirement trust fund. The Medicare Trust Fund, Social Security and DoD retirement funding plans lack this method of providing security for the future (which the Federal Government requires under ERISA of all civilian employers). Instead, no funding of the liability occurred, thus an appropriation of new tax money is needed each year to pay for retirees while current active duty continue to accrue retirement benefits that are not currently funded. As the Medicare eligible numbers climb and the numbers of retirees collecting benefits surpass active duty numbers, both programs are in desperate need of additional funding to meet increasing requirements.

The MHS and DHHS should review the accuracy and appropriateness of the LOE determination. The planned evaluation at the three-year point of the program should be made an ongoing evaluation with reported findings acted on quarterly. The MHS needs to develop an effective PLCA data collection system that organizes data in a common easily portable format that transcends service and military specific boundaries and allows accurate information to aid in business decisions.

The MOU between the DoD and the DHHS should be renegotiated at its earliest opportunity. The agreed upon HCFA reimbursement level, which is 5% below the industry standard, needs to be reviewed given the implications of the LOE and $50 million dollar cap. The MHS must acknowledge the cost avoidance enjoyed by the Medicare Trust Fund in the negotiation process, and work to a position of jointly shared

risk as both programs are similar in that they both operate from current year funding only.

This program's importance goes beyond solely providing a cost effective medical benefit for dual-eligible beneficiaries. Both DoD and Medicare have for decades promised that members participating in each program would have benefits under each program. Both programs must continue to provide promised benefits and be funded appropriately to meet earned benefits. The Medicare Trust Fund and DoD retirement funding must be required to grow funds over multiyear periods rather than rely on current year funding.

The MHS needs to actively dispel the illusion of increased program funding from Medicare. Determine the appropriate amount and mix of Medicare/DoD funding needed to adequately provide coverage for the dual eligible retiree's total health care needs.

The findings of this study indicate that the Military Health System has a disproportionately larger risk share in the TRICARE Senior Prime program than the Department of Health and Human Services and can not remain budget neutral as the program is currently structured.

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